Department of Labor & Industries
Self Insurance Section
PO Box 44892
Olympia WA 98504-4892

SIF-5 SI REPORT ON OCCUPATIONAL INJURY OR DISEASE

(ALL INFORMATION MUST BE COMPLETED)

Employer	UBI	Account ID	Claim No.

Service Co.

- ☐ INITIAL: On the date first time loss is paid
- ☐ INTERLOCUTORY ORDER REQUEST
- ☐ FINAL: On the date claim is closed by employer
- ☐ FINAL: On the date final determination is requested
- ☐ SUPPLEMENTAL: Upon Department Request
- ☐ SUPPLEMENTAL: Correction of Previous SIF 5
- ☐ WAGE ORDER requested (SIF-5A and appropriate documentation attached)
- ☐ OVERPAYMENT ORDER REQ. (SIF-5A and appropriate documentation attached)

FOR FINAL SIF-5: If employer-paid health care benefits ended, list the last date covered for each type.

Medical: _____

Dental: _____

Vision: _____

Claimant			Address
Date of injury	Last day worked	Date of lst payment	
Claim arrival date	Date returned to work	Date released for work	
Date first treated	**COMPENSATION PAID**		

From	through	@ $	per	days totaling $
From	through	@ $	per	days totaling $
From	through	@ $	per	days totaling $
From	through	@ $	per	days totaling $

☐ Time Loss Compensation	Total number of time loss days paid	Total time loss amount paid $
☐ Loss of Earning Power (see attachment for documentation)	Total number of LEP days paid	Total LEP amount paid $

Is condition medically fixed?	Is there a permanent impairment?	Attending physician
Has claimant returned to same employer?	Has time loss exceeded 90 days?	Address
E.A.R. approval date	Return to work priority (A-I)	City State ZIP

Rehab Outcome Report

Code #	Type	Cost

Remarks

Complete for Claim Closure only

- ☐ **Time loss** ☐ **Treatment only**
- ☐ **All requirements for closure of this claim by the self-insured employer have been met and are documented in our file.**
- ☐ **Final determination request of the Department of Labor and Industries. Copies of medical report and pertinent information attached.**

Notice: At time of final determination, no further medical services are authorized subsequent to the date of this report.

L&I use only

I hereby certify that I have addressed the value of the employer's contribution to any health insurance benefits and included it in the time loss rate if appropriate.

Date	Authorized Representative

NOTE: SUBMIT 1 COPY OF THIS FORM TO THE CLAIMANT AND 1 COPY TO LABOR & INDUSTRIES